Company Tracking Number: TL AR0053615F01

TOI: L04G Group Life - Term Sub-TOI: L04G.213 Specified Age or Duration -

Fixed/Indeterminate Premium - Single Life

Product Name: Term Life

Project Name/Number: Term Life/TL AR0053615F01

### Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Term Life SERFF Tr Num: AEGX-126393294 State: Arkansas
TOI: L04G Group Life - Term SERFF Status: Closed-Approved-State Tr Num: 44153

Closed

Sub-TOI: L04G.213 Specified Age or Duration - Co Tr Num: TL AR0053615F01 State Status: Approved-Closed

Fixed/Indeterminate Premium - Single Life

Filing Type: Form Reviewer(s): Linda Bird

Author: SPI ADMSLH Disposition Date: 11/23/2009
Date Submitted: 11/20/2009 Disposition Status: Approved-

Closed

Implementation Date Requested: Implementation Date:

State Filing Description:

#### **General Information**

Project Name: Term Life Status of Filing in Domicile:
Project Number: TL AR0053615F01 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:

Explanation for Combination/Other: Market Type: Group

Submission Type: New Submission Group Market Size: Small and Large Overall Rate Impact: Group Market Type: Association

Filing Status Changed: 11/23/2009 Explanation for Other Group Market Type:

State Status Changed: 11/23/2009

Deemer Date: Created By: SPI ADMSLH

Submitted By: SPI ADMSLH Corresponding Filing Tracking Number:

Filing Description:

RE: Group Life Insurance Applications GUL033(05)AR, GUL034(05)AR, GUL060(05)AR, GUL061(05)AR, and

GUL062(05)AR

The five referenced applications for group life insurance are submitted for your review and approval. Each application replaces an existing application that was previously approved by your Department. The referenced applications contain the life insurance replacement question that is required per Rule 97 to be on life insurance applications used with direct response marketed group life policies. The applications will be used on and after January 1, 2010.

SERFF Tracking Number: AEGX-126393294 State: Arkansas
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 44153

Company Tracking Number: TL AR0053615F01

TOI: L04G Group Life - Term Sub-TOI: L04G.213 Specified Age or Duration -

Fixed/Indeterminate Premium - Single Life

Product Name: Term Life

Project Name/Number: Term Life/TL AR0053615F01

The applications are designed to be used in Arkansas only and, thus, are not required to be filed in the company's domicile state of Vermont.

Applications GUL033 (05)AR, GUL034(05), and GUL062(05)AR will be used when soliciting out of state group term to age 65 life insurance policy GM274. The policy is issued to various association and credit card groups that are sitused in Illinois. The policy and certificate GC274 were approved by your Department on 9/16/1999.

Applications GUL060 (05)AR and GUL061(05) will be used when soliciting out of state group term to age 65 life insurance policies GM267 and GM287. The policies are issued to various association and credit card groups that are sitused in Illinois. Policy GM267 and certificate GC267 were approved by your Department on 2/12/1998. Policy GM287 and certificate GC287 were approved by your Department on 3/3/2004.

### **Company and Contact**

#### **Filing Contact Information**

Sam Hunt, Manager, Product Filing & shunt@aegonusa.com

Compliance

20 Moores Road 610-648-5816 [Phone] Frazer, PA 19355 610-648-4703 [FAX]

**Filing Company Information** 

Stonebridge Life Insurance Company CoCode: 65021 State of Domicile: Vermont
29 South Main Street Group Code: 468 Company Type: Life and Health

FEIN Number: 03-0164230

Rutland, VT 05701-5014 Group Name: State ID Number:

Validate, VI 00701 3014 Cloup Name. Clate is Namber

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## **Filing Fees**

Fee Required? Yes

(410) 685-5500 ext. [Phone]

Fee Amount: \$100.00

Retaliatory? No

Fee Explanation:

Per Company: No

SERFF Tracking Number: AEGX-126393294 State: Arkansas

Filing Company: Stonebridge Life Insurance Company State Tracking Number: 44153

Company Tracking Number: TL AR0053615F01

TOI: L04G Group Life - Term Sub-TOI: L04G.213 Specified Age or Duration -

Fixed/Indeterminate Premium - Single Life

Product Name: Term Life

Project Name/Number: Term Life/TL AR0053615F01

COMPANY AMOUNT DATE PROCESSED TRANSACTION #
Stonebridge Life Insurance Company \$100.00 11/20/2009 32204568

Company Tracking Number: TL AR0053615F01

TOI: L04G Group Life - Term Sub-TOI: L04G.213 Specified Age or Duration -

Fixed/Indeterminate Premium - Single Life

Product Name: Term Life

Project Name/Number: Term Life/TL AR0053615F01

## **Correspondence Summary**

#### **Dispositions**

Status	Created By	Created On	Date Submitted
Approved-	Linda Bird	11/23/2009	11/23/2009
Closed			

SERFF Tracking Number: AEGX-126393294 State: Arkansas
Filing Company: Stonebridge Life Insurance Company State Tracking Number: 44153

Company Tracking Number: TL AR0053615F01

TOI: L04G Group Life - Term Sub-TOI: L04G.213 Specified Age or Duration -

Fixed/Indeterminate Premium - Single Life

Product Name: Term Life

Project Name/Number: Term Life/TL AR0053615F01

## **Disposition**

Disposition Date: 11/23/2009

Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Company Tracking Number: TL AR0053615F01

TOI: L04G Group Life - Term Sub-TOI: L04G.213 Specified Age or Duration -

Fixed/Indeterminate Premium - Single Life

Product Name: Term Life

Project Name/Number: Term Life/TL AR0053615F01

Schedule	Schedule Item	Schedule Item Status Public Access
Supporting Document	Flesch Certification	Yes
Supporting Document	Application	No
Form	Application	Yes

Company Tracking Number: TL AR0053615F01

TOI: L04G Group Life - Term Sub-TOI: L04G.213 Specified Age or Duration -

Fixed/Indeterminate Premium - Single Life

Product Name: Term Life

Project Name/Number: Term Life/TL AR0053615F01

#### Form Schedule

Lead Form Number: GUL033(05)AR

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	GUL033(0:	5 Application/ Application Enrollment Form	Initial		47.600	GUL033(05)A R.PDF
	GUL034(09) )AR	5 Application/ Application  Enrollment  Form	Initial		47.200	GUL034(05)A R.PDF
	GUL060(09 )AR	5 Application/ Application  Enrollment  Form	Initial		44.800	GUL060(05)A R.PDF
	GUL061(09 )AR	5 Application/ Application  Enrollment  Form	Initial		47.400	GUL061(05)A R.PDF
	GUL062(0:	5 Application/ Application Enrollment Form	Initial		47.600	GUL062(05)A R.PDF

#### **Underwritten Term Life Insurance**

**Yes!** Please enroll me for the Group Term Insurance Plan Please check the rate chart for your benefit and premium based on your age, gender and tobacco usage.

Benefit Requested: \$50,000.00 Premium Amount: \$11.00

Enroll me for the Group Life Insurance Plan under the Group Policy issued to JCPenney. I also understand that in order to enroll for this coverage, I, the applicant, must be a JCPenney Credit Cardholder or the spouse of a JCPenney Credit Cardholder, age 18 through 60, and reside in a state in which this insurance may legally be offered. If accepted, and premiums are paid, I understand the Certificate is not effective until the effective date specified on my Certificate Schedule

remiums are paid, I understand the Certificate is not Page.	t effective until the effective date specified on my	Certificate Schedule
John Q. Public 1000 Anywhere Street Any Town, USA 75000	Date of Birth: 01/05/1968 Home Telephone: 972-222-22 Tobacco user within the last 12 mon	
	☐ Male ☐ Female	
(A) During the past five (5) years have you sought hospitalized for cancer, stroke, diabetes, blood kidneys, intestines, respiratory system, or for r disorder?	pressure, or for a disease of the heart, liver,	,
(B) During the past five (5) years have you sought hospitalized for alcoholism, drug abuse or been are has your license to drive been suspended or revoke	rested or cited for the use of alcohol or drugs, or	
(C) Have you ever received medical diagnosis or a AIDS Related Complex (ARC), immunodeficiency test?		
(D) Will this coverage replace, discontinue or chan	nge an existing policy or contract?	☐ Yes ☐ No
Beneficiary Designation: Any amount due for loss wince the living lawful including stepchildren and adopted children); otherwestate.	spouse; otherwise equally to your then living la	awful children, if any
Beneficiary: Jane Q. Public	Relationship: Wife	
authorize any licensed physician, medical practitions are company, consumer reporting agency (CR Bureau (MIB) to give Stonebridge Life Insurance Conton me or any member of my family to use for underwexcept for information received from MIB, to any consurance or request benefits. This authorization shotocopy of this authorization shall be as valid as the eceived and read the Medical Information Bureau No	RA), insurance support organization (ISO), or the mpany (company) or its reinsurers any information writing insurance. The company may disclose information CRA, ISO, or to any life insurance company shall be valid for two years from the date of the original, and a copy is available to the applicant	e Medical Information it has in its records ormation to MIB and to whom I apply for this application.
Any person who, with intent to defraud or knowing application or files a claim containing a false or decep		surer, submits an
ζ		
nsured's Signature	Date e Life Insurance Company	
GUL033(05)AR Home O	Office: Rutland, Vermont  Jest Plano Parkway, Plano Texas, 75075-8200	NAF99

Administrative Office: 2700 West Plano Parkway, Plano, Texas 75075-8200

#### **Underwritten Term Life Insurance**

**Yes!** Please enroll me for the Group Term Insurance Plan with Accidental Death Coverage Please check the rate chart for your benefit and premium based on your age, gender and tobacco usage.

Benefit Requested: \$50,000.00 Accidental Death: \$50,000.00 Premium Amount: \$11.00

Enroll me for the Group Life Insurance Plan under the Group Policy issued to JCPenney. I also understand that in order to enroll for this coverage, I, the applicant, must be a JCPenney Credit Cardholder or the spouse of a JCPenney Credit Cardholder, age 18 through 60, and reside in a state in which this insurance may legally be offered. If accepted, and premiums are paid, I understand the Certificate is not effective until the effective date specified on my Certificate Schedule Page.

John Q. Public 1000 Anywhere Street Any Town, USA 75000	Home Telephone: 972	/05/1968 2-222-2222 tt 12 months? ☐ Yes ☐ No
hospitalized for cancer, stroke, diabetes	ou sought or received treatment or medical advices, blood pressure, or for a disease of the heat or for nervous, neuromuscular, or connective	art, liver,
	ou sought or received treatment or medical advice r been arrested or cited for the use of alcohol or l or revoked?	
	gnosis or treatment by a licensed physician for Al deficiency disorder, or tested positive on an AID	
(D) Will this coverage replace, discontinu	e or change an existing policy or contract?	☐ Yes ☐ No
for loss of life will be paid to your then livi	or loss will be paid to you if living. Unless you sping lawful spouse; otherwise equally to your then en); otherwise equally to your then living parents	n living lawful children, if any
Beneficiary: Jane Q. Public	Relationship: Wife	
insurance company, consumer reporting ag Bureau (MIB) to give Stonebridge Life Insur on me or any member of my family to use for except for information received from MIB, insurance or request benefits. This auth photocopy of this authorization shall be as we	al practitioner, hospital, clinic, or other medical gency (CRA), insurance support organization (ISC ance Company (company) or its reinsurers any ir or underwriting insurance. The company may dist, to any CRA, ISO, or to any life insurance coorization shall be valid for two years from the valid as the original, and a copy is available to the Bureau Notice accompanying this application.	O), or the Medical Information of the Medical Information it has in its records sclose information to MIB and ompany to whom I apply for date of this application.
	knowing that he/she is facilitating a fraud agair e or deceptive statement is guilty of insurance frau	
X Incurad'a Signatura	Data	
Insured's Signature Sto GUL034(05)AR	Date  onebridge Life Insurance Company  Home Office: Rutland, Vermont	NAL99

Administrative Office: 2700 West Plano Parkway, Plano, Texas 75075-8200

Home Office: Rutland, VT Administrative Office:

## Stonebridge Life Insurance Company

Benefit Amount:

2700 West Plano Parkway Plano, Texas 75075-8200  APPLICA FOR GROUP TER	ATION F		F	Premium Amo	ount:	
Applicant's Full Name		Date of Birth_	ay/Year A	ge	☐ Male ☐ Female	
Address Street No. City State	Zip		Area Code -			
	We					
Beneficiary/Relationship			er within the la			
		Yes	☐ No			
Physician's Name & Address	Str	eet No.	City	State	Zip	
Please Check Benefit Amount Desired:			/ Premium	_		
Tol	<u>Male</u> bacco User	: Non-Tobacco Us	ser <u>Tobacc</u>	<u>Fema</u> o User <u>No</u>	<u>le</u> on-Tobacco User	
	\$XX.XX	\$XX.XX	\$XX		\$XX.XX	
	\$XX.XX \$XX.XX	\$XX.XX \$XX.XX	\$XX \$XX		\$XX.XX \$XX.XX	
	\$XX.XX	\$XX.XX	\$XX		\$XX.XX	
	\$XX.XX	\$XX.XX	\$XX		\$XX.XX	
Please choose from t	the following Rider					
\$5,000 Child Rider for each child	C	\$15,000 Accid			- f D!-II-	
Child's Full Name (only if child coverage is selected) List youngest child to	irst	Gend ☐ M	er F	Date	e of Birth	
		M	□ F		1	
Attach a separate page for additional children.						
To the best of your knowledge and belief, have you:						
A. sought or received treatment or medical advice or been hospitalized disease of the heart, blood, liver, kidneys, digestive or respiratory connective tissue disorder during the past five (5) years?			•		es No No	
B. sought or received treatment or medical advice or been hospitalized the use of alcohol or drugs, or has your license to drive been suspen				ited for Y	es 🗌 No 🗌	
C. ever been treated or diagnosed by a licensed physician for AIDS, HIV, AIDS Related Complex (ARC), immunodeficiency Yes No disorder or tested positive on an AIDS-related blood test?						
If answer is "yes" to any of the above questions, please supply complections and check this box.	ete details. Includ	le diagnosis and	name, addre	ss, and date	for any doctors	
I understand that in order to apply for this coverage, I must be a JCPenney credit cardholder or the spouse of a JCPenney credit cardholder, age XX-XX, and reside in a state in which this insurance coverage may legally be offered. If accepted, and premiums are paid, I understand the Certificate is not effective until the effective date specified on my Certificate Schedule Page.						
Will this coverage replace, discontinue or change an existing policy or cor	ntract?  Yes	☐ No				
Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.						
I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, consumer reporting agency (CRA), insurance support organization (ISO), or the Medical Information Bureau (MIB) to give Stonebridge Life Insurance Company (company) or its reinsurers any information it has in its records on me or any member of my family to use for underwriting insurance. The company may disclose information to MIB and, except for information received from MIB, to any CRA, ISO, or to any life insurance company to whom I apply for insurance or request benefits. This authorization shall be valid for two years from the date of this application form. A photocopy of this authorization shall be as valid as the original, and a copy is available to the applicant on request. I have received and read the Medical Information Bureau Notice accompanying this application form.						
Applicant's Signature X		Date X				
GUL060(05)AR						

Home Office: Rutland, VT Administrative Office: 2700 West Plano Parkway

# Stonebridge Life Insurance Company APPI ICATION FORM

Benefit Amount: \$ Premium Amount:

2700 West Plano Parkway Plano, Texas 75075-8200  Premium Amount:  FOR GROUP TERM LIFE INSURANCE PLAN  Premium Amount:  \$					ount:						
Applicant's Nam	1e (First –	Middle – Last)			Spouse's Nam	Ie (First –	Middle – La	ast) (if applying for cover	age)		
Address			☐ Male	☐ Female	Address					Male	e 🗌 Female
City		State		Zip	City		St	ate		Zip	
Birthdate	Age	Birthplace (City/State)	Telephone		Birthdate	Age	Birthp	lace (City/State)	Tele	Telephone	
1 1			( )		1 1				(	)	
Height (Ft. In.)	Weigh	nt (Lbs.) Occupation	1		Height (Ft. In.)	Weigh	nt (Lbs.)	Occupation			
Beneficiary (First	– Middle –	Last)	Relationship	)	Beneficiary (First	st – Middle	- Last)		Re	lationsh	ip
Physician's Nan	ne & Ac	Idress			Physician's Na	ıme & A	ddress				
Tobacco user w	rithin the	e last 12 months?	es No		Tobacco user	within th	ne last 1	12 months?	Yes	☐ No	
\$10,000 of \$30,000 of \$50,000 of	coveraç coveraç coveraç	ge	0,000 00,000		Please Check  \$10,000 o  \$30,000 o  \$50,000 o	f covera f covera f covera	age age age	□ \$7 □ \$7	70,000 100,00		
\$15,000 Ac \$5,000 Chil	cidenta d Rider	e following Rider options: I Death Benefit Rider for each child			\$15,000 A \$5,000 Ch	.ccident nild Ride	al Deatl er for ea				
Child's Full Nan	ne (only	if child coverage is selected Ger		t child first. ate of Birth	Child's Full Name (only if child coverage is selected.) List youngest child first.  Gender Date of Birth						st child first. Date of Birth
		M	□ F	1 1				□ M	□ F		1 1
Attach a separate page for additional children.  Attach a separate page for additional children.					Attach a separ	ate pag	je for ac	dditional children.			
To the best of your knowledge and belief, have you:  A. sought or received treatment or medical advice or been hospitaliz pressure, or for any disease of the heart, blood, liver, kidneys, digenervous, mental, neuromuscular, or connective tissue disorder during the				stive or respirat	ory sys		es, blood	Applic YE		Spouse ☐ YES ☐ NO	
B. sought or received treatment or medical advice or been hospitalize arrested or cited for the use of alcohol or drugs, or has your license to c the past five (5) years?								☐ YE	ES NO	☐ YES ☐ NO	
		d or diagnosed by a lid disorder or tested positive				elated (	Complex	x (ARC),	☐ YE	ES NO	☐ YES ☐ NO
		any of the above questi			e details. Includ	e diagr	nosis ar	nd name, addres	s, and	d date fo	or any doctors
I understand that in order to apply for this coverage, I must be a JCPenney credit cardholder or the spouse of a JCPenney credit cardholder, age XX-XX, and reside in a state in which this insurance coverage may legally be offered. If accepted, and premiums are paid, I understand the Certificate is not effective until the effective date specified on my Certificate Schedule Page.											
Will this coverage replace, discontinue or change an existing policy or contract? You: Yes No Your Spouse: Yes No											
Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.											
I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, consumer reporting agency (CRA), insurance support organization (ISO), or the Medical Information Bureau (MIB) to give Stonebridge Life Insurance Company (company) or its reinsurers any information it has in its records on me or any member of my family to use for underwriting insurance. The company may disclose information to MIB and, except for information received from MIB, to any CRA, ISO, or to any life insurance company to whom I apply for insurance or request benefits. This authorization shall be valid for two years from the date of this application form. A photocopy of this authorization shall be as valid as the original, and a copy is available to the applicant on request. I have received and read the Medical Information Bureau Notice accompanying this application form.											
Applicant's Signat	ure			Date	Spouse's Signa	ature					Date
GUL061(05)AR					1						

Home Office: Rutland, VT Administrative Office: 2700 West Plano Parkway Plano Texas 75075-8200

## Stonebridge Life Insurance Company

APPLICATION FORM

Benefit Amount: \$

Premium Amount:

Plano, Texas 75075-8200 FC	OR GROUP TERM LIFE	E INSURAI	NCE PLAN		\$	ι.
Applicant's Full Name			Date of Birth_	ay/Year A	.ge	☐ Male ☐ Female
AddressStreet No.				Area Code -		
Occupation Street No.	City State Height	<sup>Zip</sup> Wei			City State	
Beneficiary/Relationship		1.			City State st 12 months?	]Yes □ No
Physician's Name & Address						
		Stre	eet No.	City	State	Zip
Please Check Benefit Amount Desired:		<u>Male</u>	Monthly	Premium	<u>Female</u>	
	Tobacco Use		n-Tobacco Use	r <u>Tobacc</u>		Tobacco User
\$10,000 of coverage at your current age of XX cost			\$XX.XX	\$XX		\$XX.XX
\$30,000 of coverage at your current age of XX cost			\$XX.XX	\$XX	.XX	\$XX.XX
\$50,000 of coverage at your current age of XX cost	s \$XX.XX		\$XX.XX	\$XX	.XX	\$XX.XX
\$70,000 of coverage at your current age of XX cost	s \$XX.XX		\$XX.XX	\$XX	.XX	\$XX.XX
\$100,000 of coverage at your current age of XX cos	sts \$XX.XX		\$XX.XX	\$XX	.XX	\$XX.XX
	ase choose from the follow	wing Rider	•			
\$5,000 Child Rider for each child			\$15,000 Accid	lental Death B		
Child's Full Name (only if child coverage is selected) Lis	st youngest child first		Gend		Date of	f Birth
			□ M	□ F		1
Au 1			■ M	☐ F		1
Attach a separate page for additional children.						
To the best of your knowledge and belief, have you:  A. sought or received treatment or medical advice or disease of the heart, blood, liver, kidneys, digesting connective tissue disorder during the past five (5) y	ve or respiratory system,				ioi aiij	□ No □
B. sought or received treatment or medical advice or the use of alcohol or drugs, or has your license to compare the second seco					ited for Yes	□ No □
C. ever been treated or diagnosed by a licensed phy disorder or tested positive on an AIDS-related bloo		DS Related	Complex (ARC	C), immunodef	ficiency Yes	□ No □
If answer is "yes" to any of the above questions, pleat consulted. Attach a separate sheet of paper and check	se supply complete deta this box.	ils. Includ	e diagnosis and	I name, addre	ss, and date for	any doctors
I understand that in order to apply for this coverage, I r XX, and reside in a state in which this insurance cover not effective until the effective date specified on my Cer	age may legally be offere					
I authorize any licensed physician, medical practitione reporting agency (CRA), insurance support organizatio (company) or its reinsurers any information it has in its disclose information to MIB and, except for information insurance or request benefits. This authorization shall be as valid as the original, and a copy is available to accompanying this application form.	n (ISO), or the Medical In records on me or any men n received from MIB, to a e valid for two years from	nformation mber of my any CRA, I the date of	Bureau (MIB) to family to use fo ISO, or to any I this application	give Stonebr r underwriting ife insurance form. A photo	ridge Life Insural insurance. The company to who copy of this auth	nce Company company may om I apply for orization shall
Will this coverage replace, discontinue or change an exi	isting policy or contract?	☐ Yes ☐	No			
Any person who, with intent to defraud or knowing the containing a false or deceptive statement is guilty of instructions.		ı fraud aga	iinst an insurer,	submits an a	application or file	es a claim
Applicant's Signature X			_ Date X			
GUL062(05)AR						

Company Tracking Number: TL AR0053615F01

TOI: L04G Group Life - Term Sub-TOI: L04G.213 Specified Age or Duration -

Fixed/Indeterminate Premium - Single Life

Product Name: Term Life

Project Name/Number: Term Life/TL AR0053615F01

## **Supporting Document Schedules**

Item Status: Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachment:

AR - READABILITY CERTIFICATION.PDF

Item Status: Status

Date:

Bypassed - Item: Application

Bypass Reason: n/a

**Comments:** 

#### STATE OF ARKANSAS

#### READABILITY CERTIFICATION

**COMPANY NAME:** Stonebridge Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
GUL033(05)AR	47.6
GUL034(05)AR	47.2
GUL060(05)AR	44.8
GUL061(05)AR	47.4
GUL062(05)AR	47.6

Signed:

Name: Sam Hunt

Title: Manager, Product Filing & Compliance

Sam Hunt

Date: 11/20/2009